STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, print paric	00	COMPLETED			
		155780	A. BUILDING B. WING		08/25/2011			
				ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	NAME OF PROVIDER OR SUPPLIER							
MADISO	N HEALTH CARE C	CENTER, LLC	7465 MADISON AVENUE INDIANAPOLIS, IN46227					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
F0000								
	This visit was for	r a Recertification and	F0000	This plan of correction is to	<b>)</b>			
	State Licensure S	Survey.		serve as Madison Health C	are			
				Center's credible allegation				
	Survey dates: A	ugust 22, 23, 24, and 25,		compliance. Submission of	•			
	1 1	ugust 22, 23, 24, and 23,		plan of correction does not	•			
	2011			constitute an admission by				
				Madison Health Care Cente				
	Facility number:			it's management company	•			
	Provider number	:: 155780		the allegations contained in survey report are a true and	•			
	AIM number: 20	00983560		accurate portrayal of the	<b>"</b>			
				provision of nursing care a	and			
	Survey team:			other services in this facilit				
	Leia Alley, RN,	TC		Nor does this submission	,,			
				constitute an agreement or				
	Marcy Smith, RI			admission of the survey				
	Barbara Hughes,			allegations. Madison Healtl	n			
	Karina Gates, BI			Care Center is in compliand	ce			
	Courtney Mujic,	RN		as of September 24, 2011.	We			
	Patty Allen, BSV	V		respectfully request paper				
	-			review.				
	Census bed type:	:						
	SNF: 13	-						
	SNF/NF: 47							
	Total: 60							
	Census payor typ	pe:						
	Medicare: 17							
	Medicaid: 28							
	Other: 15							
	Total: 60							
	Sample: 15							
	Sample. 13							
	These deficiencie	es reflect state findings						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11

Facility ID:

012225

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155780 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVENUE MADISON HEALTH CARE CENTER, LLC INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE cited in accordance with 410 IAC 16.2. Quality review 9/01/11 by Suzanne Williams, RN The services provided or arranged by the F0282 facility must be provided by qualified persons SS=E in accordance with each resident's written plan of care. F0282 F282 483.20(k)(3)(ii) SERVICES 09/24/2011 Based on observation, interview and BY QUALIFIED PERSONS PER record review, the facility failed to ensure CARE PLAN It is the practice of physician's orders were followed in regard Madison Health Care Center to to monitoring blood glucose levels, provide services by qualified medication administration, wearing TED persons in accordance with each resident's written plan of care. I. hose, and lab work, for 7 of 15 residents Resident #35, #24, #12, and #36 reviewed for following physician orders blood sugars are being monitored in the sample of 15. (Residents #35, 20, and insulin is being administered 27, 19, 24, 12, 36) according to the physician's order. Physicians are notified per call parameters. Resident #20 is Findings include: receiving medication according to the physician's orders. Resident 1. The clinical record for Resident #35 #27 is wearing TED hose as ordered. As noted in the survey was reviewed on 8/24/11 at 2:00 p.m. report, the lab tests (hemoglobin The diagnoses for Resident #35 included, and hematocrit) for Resident #27 but was not limited to: peripheral artery were discontinued; the hemocult disease, osteoarthritis, and diabetes stool has been completed as ordered. Resident #19 is mellitus type II. receiving medication as ordered. Resident #36 is receiving A recapitulation of the July 2011 medication as ordered and blood physician's orders for Resident #35 pressure and heartrate are being checked according to the plan of indicated Resident #35 was to have an care. II. All residents have the Accucheck (a blood test to determine the potential to be affected. This is glucose level in the blood) QID (4 times being addressed by the systems daily) at 6:00 a.m., 11:00 a.m., 4:00 p.m., described below. III. The facility policy regarding medication and 8:00 p.m. administration and documentation

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155780 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVENUE MADISON HEALTH CARE CENTER, LLC INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The Blood Glucose/Sliding Scale practices has been reviewed. Licensed nurses have been Coverage Flowsheet for Resident #35 did re-educated on this policy. This not indicate an Accucheck was done on re-education stressed the the following dates and times: 7/23/11 at importance of documenting medications and treatments as 8:00 p.m., 7/24/11 at 4:00 p.m. and 8:00 they are performed to avoid p.m., 7/25/11 at 4:00 p.m. and 8:00 p.m., incomplete documentation. The 7/27/11 at 11:00 a.m., 4:00 p.m. and 8:00 blood glucose monitoring flow p.m., 7/28/11 at 6:00 a.m. and 11:00 a.m., sheets have been reviewed and 7/29/11 at 11:00 a.m., 7/30/11 at 8:00 revised to ensure improved documentation. IV. The Director p.m., and 7/31/11 at 8:00 p.m. of Nursing or her designee is conducting quality improvement Interview with the East ADON (Assistant audits of medication and Director of Nursing) on 8/25/11 at 10:08 treatment documentation. A random sample of 5% of resident' a.m. indicated there was no s medication records, treatment documentation to verify Accuchecks were records, and blood glucose flow done on the above dates and times. sheets are being checked to ensure documentation is complete. This audit will be 2. The clinical record for Resident #20 completed three times weekly for was reviewed on 8/23/11 at 9:30 a.m. 30 days; then weekly for 30 days; The diagnoses for Resident #20 included, then monthly for 6 months. The but were not limited to: Parkinson's pharmacy consultant will assist in monitoring during routine monthly disease, gastroesophageal reflux disease, visits. Results of all audits are dysphagia, obstructive sleep apnea, reported to the facility's quality hypertension, and hydrocephalus. assurance committee monthly for additional recommendations as necessary. The July 2011 physician's recapitulation order for Resident #20 indicated 2 tabs of Divalproex ER tab 500 mg to be taken PO (by mouth) q (every) hs (night). The July 2011 MAR (Medication Administration Record) did not indicate the medication was given on 7/15/11, 7/24/11, 7/27/11, and 7/28/11.

FORM CMS-2567(02-99) Previous Versions Obsolete

RBCE11

Facility ID:

Page 3 of 25

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780			(X2) MU A. BUII B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL 08/25/2	ETED
NAME OF I	PROVIDER OR SUPPLIEI	R.	•		DDRESS, CITY, STATE, ZIP CODE		
MADISO	N HEALTH CARE (	CENTER, LLC			ADISON AVENUE APOLIS, IN46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		hysician's recapitulation	+	IAG			DATE
	order for Reside	•					
		ng to be taken PO BID					
	1 ` */	9:00 a.m. and hs (at					
		2011 MAR did not lication was given at night					
		/11, 7/24/11, 7/27/11 and					
	7/28/11.	,					
	The July 2011 p	hysician's recapitulation					
	order for Reside						
		20 mg to be taken PO					
	1 -	n. The July 2011 MAR the medication was given					
		/11, 7/27/11 and 7/28/11.					
		, 11, 7, 27, 11 414 7, 20, 11.					
		he East ADON on 8/25/11					
		dicated there was no					
		o verify the medications					
	and times.	rdered, on the above dates					
		27's clinical record was					
		2/2011 at 2:00 p.m. The					
		l documentation of					
		ving been admitted to the					
	· ·	011, with diagnoses that					
		ere not limited to,					
	and hyperthyroid	disease, dementia, anemia,					
		W-V					
	The clinical reco	ord included a physician's					
		/2011 for knee high TED					
	_	on stockings to bilateral					
	lower extremitie	es to be on at 8:00 a.m.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED
		155780	B. WIN	G		08/25/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE		
MADIOO	NULFALTU CADE C	NENTED II O		1	ADISON AVENUE		
	N HEALTH CARE C			INDIAN	APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		.m.; these times were per		mo	•		DATE
	resident request.	-					
	resident request.						
	   Resident #27 wa	s observed on 8/22/2011					
		e not wearing any TED					
	1 ^	on stockings. Resident					
	_	d on 8/24/2011 at 2:10					
		earing any TED Hose					
	compression stoc						
	1	C					
	b. Resident #27's	clinical record included					
	a physician's ord	er dated 7/14/2011 for a					
	Hemoccult stool	times 1, and a					
	Hemoglobin and	Hematocrit level to be					
	drawn weekly. I	Documentation to indicate					
	these lab tests we	ere completed, or of their					
	results, was not i	n the record.					
	Interview with th	ne DON (Director of					
	Nursing) on 8/23	/2011 at 9:25 a.m.					
	indicated that the	ese labs were missed and					
	_	he Nurse Practitioner					
		moccult stool and					
		weekly Hemoglobin and					
	Hematocrit level	on 8/23/2011.					
		s clinical record was					
		3/2011 at 10:00 a.m. The					
		documentation of					
		ying been admitted to the					
	1 *	2011, with diagnoses that					
	included, but we	· ·					
		ise, coronary artery					
	disease, hyperlip	idemia, and right hip					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155780	B. WIN			08/25/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			7465 M	ADISON AVENUE		
	N HEALTH CARE C				APOLIS, IN46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT			
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	fracture.						
		inical record included a					
		nistration record that					
	showed doses we	ere not documented as					
	given for the foll	owing medications on					
	7/27/2011:						
	Mirapex ER 0.37	75 MG tablet by mouth					
	daily.						
	Senna 8.6 MG ta	blet by mouth daily.					
	Vitamin D-3 400	IU 2 tablets by mouth					
	daily.	-					
	,						
	The missing doc	umentation of the					
		brought to the attention					
		ator on 8/23/2011 at 4:45					
		nal information was					
	provided.	nai information was					
	provided.						
	5 The clinical re	ecord of Resident #24					
		8/25/11 at 11:00 a.m.					
		cluded, but were not					
	limited to, Diabe						
	l '	cian Orders included an					
	1	7/11, for "Novolog 4 units					
		_					
		al, sliding scale accu					
	check AC et HS						
		lood Glucose/Sliding					
	1	Flowsheet, on 8-25-11 at					
		ted the HS accuchecks					
	were not done as ordered by the physician on the following dates:						
	July 15, 2011						
	July 22, 2011						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11 Facility ID:

012225

If continuation sheet

Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155780	B. WING			08/25/2	011
		ll	-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	₹		7465 M	ADISON AVENUE		
	N HEALTH CARE (	•		INDIAN	APOLIS, IN46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	July 25, 2011						
	July 26, 2011						
	July 29, 2011						
	July 30, 2011						
	July 31, 2011						
	In an interview v	with East Assistant					
	Director of Nurs	ing on 8-26-11 at 1:05					
	p.m., she indicat	ed the accu-checks were					
	not done.						
	6. The record of	f Resident #12 was					
	reviewed on 8/2	2/11 at 1:00 p.m.					
		esident #12 included, but					
	"	to, diabetes mellitus and					
	neuropathy.	to, unactor interious una					
	neuropatity.						
	A care plan for F	Resident #12, dated 5/5/11					
	1 ^	ugh 10/2011, indicated a					
		ential for hyper/hypo					
	1 ~	to diabetes." The goal					
	1 0 3	•					
		no signs of symptoms" of					
	"	d sugar. Approaches					
	1	per orderlabs per					
	ordersliding so	ale per MD order"					
	A recognitulated	ahrvaiaianta ardar far Intr					
	1	physician's order for July					
	· ·	iginal date of 6/27/11,					
		ent #12 was to receive					
	1	nger stick test to measure					
		ore meals and at bedtime					
		eceive Humalog insulin					
	according to the	following sliding scale:					
	Blood sugar of 2	250 - 300: 2 units of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RBCE11 Facility ID: 012225

If continuation sheet Page 7 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2)	MULTIPLE CO	NSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00		COMPL	
		155780	B. W.	ING			08/25/2	U11 
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE		
				I	ADISON AVENU			
MADISO	N HEALTH CARE C	CENTER, LLC		INDIAN	APOLIS, IN4622	27		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCI	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEF	TCIENC I)		DATE
	insulin	00 250 4 4 6						
	_	00 - 350: 4 units of						
	insulin	70 400 C :/ C						
	_	50 - 400: 6 units of						
	insulin	4 1 11 1:04						
		as to be called if the						
	resident's blood s	sugar was over 400.						
	A physician's and	der, dated 7/13/11,						
		ent #12 was to receive						
		e times per day before						
		o receive Humalog insulin						
		following sliding scale:						
	according to the	following stiding scale.						
	Blood sugar of 20	201 - 250: 2 units						
	Blood sugar of 2:							
	Blood sugar of 30							
	Blood sugar of 3:							
	Blood sugar of 4	01 - 450: give 10 units						
	Blood sugar of 4:	50 - 500: give 12 units						
	_	as to be called if Resident						
		r was less than 70 or over						
	500.							
	Review of a Bloo	od Glucose/Sliding Scale						
	Coverage Flowsh	heet for July 2011,						
	received from the	e East Wing Assistant						
	Director of Nursi	ing on 8/24/11 at 1:05						
	p.m., indicated R	Resident #12's blood sugar						
	was not checked	on 7/2/11 before						
	breakfast and at l	bedtime, 7/3/11 before						
	breakfast, 7/4/11	before supper and at						
	bedtime, 7/8/11 b	before breakfast, lunch						
	and supper, 7/9/1	11 before breakfast, lunch						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	RBCE1	1 Facility	ID: 012225	If continuation sh	ieet Pa	ge 8 of 25

Page 8 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION 00	(X3) DATE COMPL		
ANDILAN	or connection	155780	A. BUII			08/25/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ADISON AVENUE		
MADISO	N HEALTH CARE C	ENTER, LLC			APOLIS, IN46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		/11 before breakfast and	+	IAG			DATE
		before breakfast and					
		11 before breakfast,					
	lunch and supper						
		•					
	The Blood Gluco	•					
		neet for July,2011,					
	indicated the foll	•					
		in was not given for a					
	_	10 at 4:00 p.m. Resident					
		received 2 units of					
	Humalog.	in was not given at					
		blood sugar of 320.					
	1	ould have received 6 units					
	of insulin.	did nave received 6 dints					
		in was not given at					
		blood sugar of 276.					
		ould have received 4 units					
	of insulin.						
	On 7/20/11 insul	in was not given at					
	breakfast for a bl	ood sugar of 208.					
		ould have received 2 units					
	of insulin.						
		00 a.m. before breakfast,					
		lood sugar was 58. The					
		dicate the physician was					
	notified.						
	On 8/23/11 at 8:3	35 a.m., interview with					
	the ADON indica	ated she was unable to					
	provide any furth	ner information on the					
	missing accuched	-					
	administrations a	and physician					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155780			A. BUIL	DING	NSTRUCTION  00	(X3) DATE : COMPL 08/25/2	ETED
	PROVIDER OR SUPPLIER  N HEALTH CARE C		B. WINC	STREET A	ADISON AVENUE APOLIS, IN46227		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	<b>_</b>	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
TAG	notification.	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7. a. The record of Resident #36 was reviewed on 8/24/11 at 1:30 p.m.						
	Diagnoses for Resident #36 included, but were not limited to, diabetes mellitus, end stage renal disease and morbid obesity.						
	A care plan for Resident #36, originating 7/9/10 and current through 9/2011, indicated a problem of a diagnosis of diabetes with potential for complications.  A goal was "Minimize risk for complications from" diabetes.						
	Approaches included "Accuchecks and insulin per MD order"  A recapitulated physician's order for July 2011, with an original order date of 7/9/10, indicated Resident #36 was to have her blood sugar checked before meals and at bedtime. The physician was supposed to be called if the blood sugar was less than 70 or over 400.						
	Coverage Flowsh indicated Resider not checked on 7 before supper and before lunch and lunch and supper	od Glucose/Sliding Scale neet for July 2011, nt #36's blood sugar was /2/11 at bedtime, 7/7/11 d at bedtime, 7/16/11 before t, 7/17/11 before lunch					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11 Facility ID:

012225

If continuation sheet

Page 10 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/25/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADISON AVENUE	00/23/2	.011
MADISO	N HEALTH CARE C	ENTER, LLC			APOLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	7/28/11 before bi	nch, 7/25/11 at bedtime, reakfast and lunch, ne, 7/30/11 at bedtime dtime.					
	On 8/24/11 at 4:50 p.m. the West Wing ADON indicated she had no further information regarding the above missing blood sugars.						
	b. A recapitulated physician's order for July 2011, with an original order date of 7/9/10, indicated Resident #36 was to receive Metoprolol 50 milligrams every day for high blood pressure. This medication was not to be given if Resident #36's systolic blood pressure was less than 100 or her heart rate was less than 60.						
	A care plan for Resident #36, dated 7/9/10 and current through 9/2011, indicated Resident #36 had the potential for complications related to her diagnosis of high blood pressure. The goal was to minimize the risk of complications and an approach was "1. Monitor B/P [blood pressure] per MD order3. Administer meds [medications] per MD order"						
	2011, for Resider the medication w	ication Record for July nt #36 did not indicate as given on July 2, 3, 19 indicated on July 1, 9,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155780			(X2) MULTIPL  A. BUILDING  B. WING		TRUCTION  00	(X3) DATE S COMPL 08/25/20	ETED
NAME OF I	PROVIDER OR SUPPLIEF	<b>"</b> {			DRESS, CITY, STATE, ZIP CODE		
MADISO	N HEALTH CARE (	CENTER, LLC			DISON AVENUE POLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
	was given witho # 36's blood pres parameters order to giving the me  During an interv Assistant Directe at 4:50 p.m., she further informati Resident #36 rec July 2, 3, 19 and pressure and hea July 1, 9, 14, 23, administration o  An undated facil the Director of N p.m. titled "Prep Guidelines Secti Administration - Policy"Medica prescribedC. E individual who a medication dose administration o  [Medication Adr	iew with the West Hall or of Nursing on 8/24/11 indicated she had no ion to indicate whether seived her Metoprolol on 20, 2011, or if the blood art rate were checked on 24 and 31 prior to the f the medication.  It policy received from Nursing on 8/24/11 at 3:25 aration and General on 38: Medication General Guidelines ations are administered as Documentation 1. The administers the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155780 08/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVENUE MADISON HEALTH CARE CENTER, LLC INDIANAPOLIS, IN46227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Each resident's drug regimen must be free F0329 from unnecessary drugs. An unnecessary SS=D drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. F329 483.25(I) UNNECESSARY F0329 09/24/2011 Based on interview and record review, the **DRUGS** facility failed to ensure residents were free from unnecessary medications, related to It is the practice of Madison the lack of assessment of pain prior to Health Care Center to ensure that administration of as needed (prn) pain each resident's drug regimen is free from unnecessary drugs. medication and the failure to evaluate the effectiveness of the pain medication I. Resident #11 no longer resides administered, for 3 of 8 residents in the facility. Residents #35, & reviewed for pain medications in the #59 are receiving pain medications as needed and are sample of 15. Resident #'s 11, 35 and 59. being assessed for pain prior to administration; and assessed Findings Include: again following administration for effectiveness. 1) The clinical record for Resident #59 II. All residents have the potential was reviewed on 8/23/11 at 9:15 a.m. to be affected. This is being Diagnoses for Resident #59 included, but addressed by the systems

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11

Facility ID:

012225

If continuation sheet

Page 13 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155780	B. WIN	G		08/25/2	011
NAME OF	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THINE OF	I RO VIDER OR SOLI EIEI			1	ADISON AVENUE		
MADISO	N HEALTH CARE (	CENTER, LLC		INDIAN	APOLIS, IN46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	ŧ	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		to, depression, edema,			described below.  III. The facility policy regardir		
	hypothyroidism	(where the thyroid gland			pain management has been	ig	
	does not make e	nough thyroid hormone),			reviewed. Licensed nurses l	nave	
	history of humer	rus (arm bone) fracture			been re-educated on this pol		
	and history of pe	elvic fracture.			The documentation of pain		
					assessment and pain relief v	vill no	
	A review of the	facility Medication			longer be placed on the		
		Record (MAR) for			medication administration re (MAR) but will be documente		
		dicated Resident #59 had			the pain flow sheet. License		
		er for Hydrocodone/APAP			nurses have been educated		
	1	co, narcotic pain			the use of this flow sheet.		
	1	•					
		e one tablet by mouth			IV. The Director of Nursing o		
	1 -	as needed for moderate			designee is conducting quali improvement audits of medic		
	pain.				and treatment documentation		
					random sample of 5% of res		
	The MAR indica	ated Resident #59			s medication records, treatm		
	received the pair	n medication on 7/15/11 at			records, and pain flow sheet	s are	
	4:00 p.m. and or	n 7/16/11 at 5:00 a.m.			being checked to ensure		
	Documentation	was lacking of the			documentation is complete. audit will be completed three		
	location and leve	el of pain, whether the			times weekly for 30 days; the		
		was effective or of any			weekly for 30 days; then mo		
	pain assessment.	•			for 6 months. The pharmacy		
	Pain assessment				consultant will assist in moni	-	
	Further informat	tion was requested from			during routine monthly visits.		
		Nursing on 8/24/11 at 5			Results of all audits are repo to the facility's quality assura		
		_			committee monthly for additi		
	1 ~	ocation and level of pain			recommendations as necess		
	1 1	urses documentation of				•	
	1 -	being effective, or any					
		ation of an assessment that					
	had been done.						
	During an interv	riew with the Director of					
	1	/11 at 4:00 p.m., she					
		ther information was					
	I muicated no furt	nei mioimation was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155780	B. WIN	G		08/25/2	011
NAME OF E	PROVIDER OR SUPPLIER	<b>!!</b>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			7465 M	ADISON AVENUE		
MADISO	N HEALTH CARE C	CENTER, LLC		INDIAN	APOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<b>.</b>	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	rd to Resident #59's pain					
	assessments.						
		Resident #11 was					
		3/11 at 11:55 a.m.					
	1 ~	esident #11 included, but					
	were not limited	to, peri-rectal abscess					
	and end stage rer	nal disease.					
		ler dated 8/16/11, the day					
		s admitted to the facility,					
		ld receive Norco 5/325					
	1	every 4 - 6 hours as					
	needed, 1 tab for	mild pain or 2 tabs for					
	severe pain.						
	D. iC. M.	Ľ/ D11					
		lication Record and a					
	_	Record for Resident #11					
	1	, indicated he received 2					
		11 at 12:00 p.m., 2					
		11 at 8:00 p.m., 2 Norcos					
		0 a.m., 2 Norcos on					
	_	.m., 2 Norcos on 8/21/11					
	1	orcos on 8/22/11 at 5:00					
	p.m. and 2 Norco	os on 8/23/11 at 12:30					
	a.m.						
	No do	on wood form die Danidand					
		on was found in Resident					
		ndicate the location or					
	severity of his pain prior to the						
		f the medication or the					
		the medication after					
	administration.						
	Duming an intern	ion with the Director of					
	During an intervi	iew with the Director of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11 Facility ID:

012225

If continuation sheet

Page 15 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155780		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155780	B. WIN		DDDFGG GITY CTATE TIN CODE	08/25/2	UII
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ADISON AVENUE		
	N HEALTH CARE C				APOLIS, IN46227		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Nursing on 8/24/	11 at 11:13 a.m. she					
	indicated she had	I no further information					
		ment of the resident's pain					
	-	wing the administration					
	of Norco.	and for Davidant #25					
		ecord for Resident #35 8/24/11 at 2:00 p.m.					
		or Resident #35 included,					
	_	ited to: peripheral artery					
		nritis, and diabetes					
	mellitus type II.						
		nysician's recapitulation					
		Tylenol 650 mg P.O. (by					
		4 hours PRN (as needed)					
	for pain.						
	The July 2011 M	AR (Medication					
	Administration R	Record) was reviewed on					
	8/24/11 at 2:30 p	.m. It indicated Tylenol					
		n on 7/24/11 (no time					
	f :	11 at 12:00 a.m., 7/28/11					
	_	7/29/11 at 3:30 p.m.					
		cumentation to indicate assessed for the location					
		re of the pain prior to					
	_ ·	e pain medication or for					
	_	of the medication after					
	the medication w						
	Resident #35's ca	are plan for pain was					
		5/11 at 12:09 p.m. The					
	•	ed an approach was to					
	observe effective	eness of medications.					

li ´		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 08/25/20	ETED
	PROVIDER OR SUPPLIER		7	465 MA	DRESS, CITY, STATE, ZIP CODE DISON AVENUE POLIS, IN46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0371 SS=F	Guidelines policy on 8/24/11 at 3:0 8/25/11 at 12:53 indicated that whadministered, the for which the me well as the result the dose are to be 3.1-48(a)(6)  The facility must - (1) Procure food from the facility must - (2) Store, prepare under sanitary cor Based on observe the facility failed stored in a mannintegrity of the prodent and insect failed to date from order to know who perishable food. 59 residents who kitchen of 60 residents included A tour of the kitches.	rom sources approved or ctory by Federal, State or nd distribute and serve food aditions ation and record review, to ensure dry food was er to maintain the ackaging and to prevent infestation. The facility zen perishable food in then to discard the frozen This potentially affected ate food from the idents residing in the	F037	1	F371 – FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY It is the practice of Madison Health Care Center ensure that food is stored in a manner to maintain the integrof the packaging and to prever ordent and insect infestation. The hamburger buns, vanilla wafers, and strawberry crean were disposed of at time of observation. II. All residents the potential to be affected. is being addressed by the systems described below.III. 8-23-11 the dietary manager education with the dietary stathe facility policy on food stor containing information on lab and dating open items. IV. T	of to a rity ent I. n pie have This On did aff on age eling	09/24/2011

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE  A. BUILDING  B. WING	O0	(X3) DATE COMP 08/25/2	LETED
	PROVIDER OR SUPPLIEF		7465	T ADDRESS, CITY, STATE, ZIP CODE MADISON AVENUE ANAPOLIS, IN46227	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	area, a package of hamburger buns good through da count package of observed with a approximately 3 packaging, expopackage of open observed in an uto air, with no oppackage. Anothe vanilla wafers we no open or use but to air, with no oppackage. Anothe vanilla wafers we no open or use but to air, with no oppackage. Anothe vanilla wafers we no open or use but to air, with no oppackage of the count package of the box, we date. Approxime cream pie was of use by date.  The Refrigerator provided by the at 9:30 a.m., was 11:01 a.m. The supervisors will ensuring food its expired or past parts.	inches in diameter, in the sing the buns to air. A sed vanilla wafers was insealed package, exposed ben or use by date on the er package of opened as observed, sealed, with y date on the package.  Ion of the freezer, an 8 if waffles was observed, with no open or use by ately half of a strawberry observed with no open or use of served		Dietary Manager will do a thru of food storage area each tour of duty. The die manager and the dieticia both conduct a sanitation the kitchen which will incomplete storage. These audits with done on a monthly basis continued basis. Results audits are reported to the quality assurance commitmentally for additional recommendations as necessary.	s on tary n will audit of ude food ll be on a of all facility's	
	-	ice sheet, provided by the a 8/24/11 at 9:30 a.m. and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RBCE11 Facility ID:

cility ID: 012225

If continuation sheet

Page 18 of 25

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	I i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP COD ADISON AVENUE IAPOLIS, IN46227	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	indicated after of must put an open all products must the product.  The Food Receive provided by the part of the product at 9:30 a.m., was 10:55 a.m. The product of the pr	bening a product you a date on the product and thave a used by date on the date on the product and thave a used by date on the date on the policy, Administrator on 8/24/11 areviewed on 8/25/11 at policy indicated all foods exer will be dated with a				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
		155780	A. BUILI B. WING			08/25/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADISON AVENUE		
MADISOI	N HEALTH CARE C	CENTED II.C			APOLIS, IN46227		
IVIADISOI	NTIEALITI CARE C	CENTER, LLC		INDIAN	AFOLIS, IN40221		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0441		establish and maintain an					
SS=D		Program designed to provide					
		nd comfortable environment					
		nt the development and sease and infection.					
	transmission or dis	sease and injection.					
	(a) Infection Contr	ol Program					
		establish an Infection Control	1				
	Program under wh						
	` '	ontrols, and prevents					
	infections in the fa	•					
		procedures, such as					
isolation, should be applied to an individual resident; and		e applied to an individual					
	(3) Maintains a record of incidents and corrective actions related to infections.						
	corrective actions	related to injections.					
	(b) Preventing Spr	read of Infection					
		ction Control Program					
	· ·	resident needs isolation to					
		d of infection, the facility					
	must isolate the re	<del>_</del>					
	(2) The facility mu	st prohibit employees with a					
		ease or infected skin					
		t contact with residents or					
		contact will transmit the					
	disease.						
	` '	st require staff to wash their					
		direct resident contact for					
	professional pract	ng is indicated by accepted					
	professional pract	ice.					
	(c) Linens		1				
	` '	andle, store, process and	1				
		as to prevent the spread of	1				
	infection.	·	1				
	Based on observa	ation, record and	F04	<b>14</b> 1	F441 483.65 (a)(1) INFECTION		09/24/2011
	interview, the fac	cility failed to ensure staff			CONTROL It is the practice of Madison Health Care Center to maintain an infection control		
		equipment, after use on	1			to	
		5 and 28, to prevent the	1				
		• •	1		program designed to provide		
	spread of infection	on for 3 of 4 residents	1		safe, sanitary, and comfortab	лe	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155780	A. BUI B. WIN	LDING		08/25/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1			
			1	ADISON AVENUE			
MADISO	N HEALTH CARE (	CENTER, LLC		INDIAN	APOLIS, IN46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed with a	potential to affect 25 of	l		environment and to help pre	vent	
	25 residents resi	ding in rooms assigned			the development and		
	for day time care	•			transmission of disease and		
	101 day time care	by LIN #1.			infection. I. Residents #16, #	25, &	
					#28 had no adverse		
	Findings include	<del>.</del>			consequences from LPN #1'		
					failure to clean her stethosco between residents. II. All	he	
	On 8/23/11 at 9	:05 A.M. LPN #1 was			residents have the potential	<sub>to he</sub>	
	observed using h	ner stethescope, hanging			affected. This is being addre		
	1	nd blood pressure cuff she			by the systems described be		
		er pocket, to take the			III. A new policy has been		
		•			developed that includes clea	ning	
	blood pressure of Resident # 16 and				the stethoscope between		
	Resident #25 during the administration of				residents to prevent the pote		
	medication, and	not cleaning this			spread of infection. The clea	~ 1	
	equipment prior	to use on residents,			procedure includes the use of		
	between use, or	after use.			EPA (Environmental Protecti		
					Agency) approved germicide		
	On 9/24/11 of 16	):00 A.M. LPN #1 was			Nursing personnel have bee educated regarding this new		
					policy which includes cleanir		
	_	ner stethescope and blood			before and following each us	-	
	1 -	Resident #28 to listen to			Blood pressure cuffs and res		
	chest sounds wh	en giving a breathing			equipment will be cleansed v		
	treatment, and d	id not clean this			10% sodium hypochlorite		
	equipment befor	e use.			germicide when visibly		
	1	-			soiled. Blood pressure cuffs		
	On 8/22/11 of 16	0:05 an interview was			also be checked weekly to e		
					cleanliness. IV. The Director	ot	
		LPN #1 who was asked			Nursing or her designee is	ont	
		eans her stethescope and			conducting quality improvem audits of stethoscope cleaning		
	blood pressure c	uff between residents.			between resident use. A rar	٠ ,	
	She indicated the	at she cleans this			sample of 5 nursing personn		
	equipment between	een "every couple of			be monitored weekly during		
	residents."	J F			routine use of the equipment	t.	
	105idelits.				This QI audit will continue w		
	D	. ( ) 1			for 30 days; then every other		
		nt facility policy supplied			week for 30 days; then mont		
	by DON on 8/24	1/11 at 3:00 P.M. indicates			for 6 months. Results of all a	udits	
	I that reusable equ	ipment is not to be used			are reported to the facility's		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			LETED	
		155780			<del></del>	08/25/2	011
			B. WINC		DDDFGG CITY CTATE TID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MADICO	NUITALTILOADE O	PENTED II C			ADISON AVENUE		
MADISO	N HEALTH CARE C	ENTER, LLC		INDIAN	APOLIS, IN46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	for the care of an	other resident until it has			quality assurance committee		
	been appropriate	ly cleaned and			monthly for additional		
reprocessed.				recommendations as necess	sary.		
	· F						
	3.1-18(j)						
F0504 SS=D		rovide or obtain laboratory n ordered by the attending					
		review and interview, the	F0:	504	F504 483.75(j)(2)(i)		09/24/2011
		ensure there was a			LABORATORY SERVICES		
	-	for a lab that was drawn			It is the practice of Madison		
		nts reviewed for having			Health Care Center to provid		
		•			obtain lab services when ord	erea	
		for labs in a sample of			by the physician.		
	15. (Resident #12	2)			I. Resident #12's physician v	vas	
					notified of the lab test that wa		
	Findings include	d:			done without an order.		
	The record of Re	sident #12 was reviewed			II. All residents have the pote		
	on 8/22/11 at 1:0	0 p.m.			to be affected. This is being		
		F			addressed by the systems		
	Diagnoses for Re	esident #12 included, but			described below.		
	_	,			III. Lab orders are reviewed		
		to, diabetes mellitus and			during morning clinical meeti	ina	
	left femur fractui	e.			and checked to ensure that t	-	
					lab test has been transcribed		
	Review of labs d	rawn on Resident #12			the requisition correctly. Nur		
	included a Comp	rehensive Metabolic			have been re-educated on the		
	Panel drawn 7/7/	11. A physician's order			system for ordering lab tests	•	
	for this lab was n	not found in the resident's			IV. The Director of Nursing o	r her	
	record.				designee is conducting quali		
					improvement audits of lab te	-	
	During on interes	iow with the East Wine			A random sample of 5% of		
	_	iew with the East Wing			resident's clinical records are	e	
		or of Nursing on 8/23/11			being checked to ensure the		
	at 8:35 a.m., she	indicated there was no			test that was completed has	а	
			1				ı

012225

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155780	B. WING			08/25/2	011
	PROVIDER OR SUPPLIER		<b>.</b>	STREET A	ADDRESS, CITY, STATE, ZIP CODE ADISON AVENUE APOLIS, IN46227		
					AFOLIS, IN40221		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1110		· · · · · · · · · · · · · · · · · · ·	1	1110	current physician's order in		DATE
order written for the lab draw. She indicated "She got an extra lab drawn."  3.1-49(f)(1)				place. This audit will be completed three times week! 30 days; then weekly for 30 of then monthly for 6 months. Results of all audits are report to the facility's quality assurations committee monthly for additional recommendations as necessing place.	days; rted nce onal		
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to ider the resident's asse and services provi	naintain clinical records on accordance with accepted ards and practices that are ely documented; readily estematically organized.  must contain sufficient attify the resident; a record of essments; the plan of care ded; the results of any ening conducted by the ess notes.					
	Based on record interview, the factor resident had physical for oxygen to be residents whose or reviewed in a sar Resident #27.  Findings include Resident #27's clareviewed on 8/22 record contained Resident #27 have	review, observation, and cility failed to ensure a sician's orders obtained discontinued, for 1 of 15 clinical records were mple of 15 residents.  : : : : : : : : : : : : : : : : : :	F0	514	F514 483.75(I)(1) RES RECORDS-COMPLETE/ACC ATE/ACCESSIBLE  It is the practice of Madison Health Care Center to mainta each resident's clinical record accordance with accepted professional standards and practices that are complete; accurately documented; read accessible; and systematical organized.  I. Resident #27's physician wanotified and an order was obtained to discontinue the unoxygen.  II. Residents who utilize oxygen.	ain d in lily ly vas se of	09/24/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155780	B. WIN			08/25/2011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADISON AVENUE		
MADISO	N HEALTH CARE (	CENTER, LLC		1	APOLIS, IN46227		
				L		(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO	ON
TAG	` `	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E DATE	OIV
		disease, dementia, anemia,	<del> </del>		have been checked to ensur	-	
					the physician's order is corre		
	and hyperthyroid	JISIII.			, ,		
		1 . 17/2/2011			III. Licensed nurses have be	en	
		er dated 7/6/2011,			re-educated to ensure that		
		te oxygen to maintain			documentation of oxygen the is placed on the treatment	rapy	
	saturation level	greater than 92%.			administration records (TAR)	and	
					if there is a change in the the		
	Nurses notes dat	red 7/9/2011, indicated			a physician's order should be	• • •	
	that saturation w	as at 98% on oxygen at 3			obtained. Additional system		
	Liters per nasal	cannula.			changes are being addresse	<b>I</b>	
					through our quality improven program as indicated below.	ient	
	Resident #27 wa	as observed on 8/22/2011			program as indicated below.		
	at 2:40 p.m. not	wearing oxygen.			IV. The Director of Nursing o	r her	
					designee is conducting quali		
	An interview wi	th the DON (Director of			improvement audits of oxyge	<b>I</b>	
		3/2011 at 3:05 p.m.,			therapy. A random sample of	<b>I</b>	
	1	•			of resident's clinical records		
		ent #27 was weaned off			being checked to ensure that oxygen therapy is in use the	<b>I</b>	
		nately one week after			a current physician's order in	<b>I</b>	
		facility, but there was no			place. This will include a visu		
		egarding exactly when			observation of the resident.		
	this occurred.				audit will be completed three		
					times weekly for 30 days; the weekly for 30 days; then mo		
	Review of the fa	cility's Oxygen			for 6 months. Results of all	itiliy	
	Administration I	Policy, provided by the			audits are reported to the fac	ility's	
	DON on 8/24/20	)11 at 11:10 a.m.,			quality assurance committee	´	
	included, but wa	s not limited to, the			monthly for additional		
	following:	•			recommendations as necess	ary	
	"After completing	ng the oxygen setup or					
	1	following information					
		led in the resident's					
		the rate of oxygen flow,					
		• • • • • • • • • • • • • • • • • • • •					
	•	ale; the frequency and					
	duration of the ti	reatment; all assessment	1				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE COMPI - 08/25/2	LETED
	PROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP COI ADISON AVENUE APOLIS, IN46227	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	data obtained be procedure."	fore, during, and after the				
	3.1-50(a)(1) 3.1-50(a)(2)					